South Carolina Comprehensive HIV/AIDS Care Plan

Purpose

The South Carolina Comprehensive HIV/AIDS Care Plan describes goals and strategies for addressing the needs of people living with HIV/AIDS (PLWHA) in the state. It is intended to guide the coordinated and collaborative actions of the South Carolina Department of Health and Environmental Control (DHEC); Ryan White Care Act Title II, Title III, and Title IV service providers; providers of other services related to the care of PLWHA; as well as the actions of consumers themselves and other PLWHA.

This Comprehensive Plan is an extension of an earlier document, the South Carolina Statewide Coordinated Statement of Need (SCSN). The SCSN describes the findings from an assessment of the needs of PLWHA in South Carolina. This assessment identified the barriers, gaps and needs of PLWHA and served as the starting point for the development of the goals and objectives described in this Comprehensive Plan.

SCSN Process

The SCSN was developed in a multi-step process. DHEC Central Office staff updated the South Carolina epidemiologic profile and the resource inventory in July 2001. This draft document was distributed to Title II, Title III, Title IV, and SEATC providers, as well as persons living with HIV/AIDS (PLWHA), partners in care - SC Department of Corrections, DAODAS, HOPWA providers, HIV prevention, Minority HIV/AIDS Demonstration Project, and Medicaid for review, and with a request for current needs assessment data. Submissions were received from: Minority HIV/AIDS Demonstration Project, six Title II consortia, and two Title III providers. The Midlands Care Consortium included a housing assessment with their submission. During the September 2001 Ryan White All Titles Quarterly Meeting, the second draft of the SCSN, including epi profile, resource inventory and updated needs assessment information was distributed to the 73 attendees. (The total does not equal 73 as some individuals represented more than one type of stakeholder). Participation across all titles from an inclusive group of stakeholders ensured that the issues identified are cross cutting issues, across geographic areas (rural versus urban), demographics (gender, age and race) and the entire spectrum of diseases.

Stakeholder Type	Number Represented	Stakeholder Type	Number Represented
Title II	46	DHEC	12
Title III	8	ADAP	3
Title IV	6	Dept. of Corrections	1
PLWHA	9	AETC	2
Prevention	2	Dental	1
Medicaid	1	Minority Health	1

The attendees broke into small groups to review and discuss:

- Unmet needs of persons and families living with HIV/AIDS
- Impact of co-morbidities on care and services
- Barriers to care and gaps in service delivery
- Linkages between prevention and care
- Outreach and education to increase access for minorities to ADAP
- Resource Inventory
- Critical issues impacting the delivery of HIV care services

This review identified 14 areas of need, which were submitted as Barriers, Gaps, and Needs in the South Carolina SCSN and will be presented as the basis of the Comprehensive Plan. Additionally, a statewide consumer survey of needs was conducted in late 2001. Those results were also reviewed and included as appropriate. The Needs Assessment process is ongoing and multifaceted. A provider survey will be conducted later this year and those results will be incorporated into the SCSN. Plans to conduct focus groups and key informant interviews throughout the state will be implemented during the next fiscal year.

Comprehensive Plan Process

This plan was developed collaboratively with the input of a broad spectrum of HIV/AIDS stakeholders. A full-day meeting was convened with 56 participants on June 13, 2002 to develop the goals and objectives described in this Comprehensive Plan. The table below shows the type and number of stakeholders represented at this meeting. (The total does not equal 56 as some individuals represented more than one type of stakeholder).

Stakeholder Type	Number Represented	Stakeholder Type	Number Represented
Title II	34	DHEC	5
Title III	14	ADAP	2
Title IV	2	Dept. of Corrections	2
PLWHA	10	AETC	1

DHEC distributed a draft of the Comprehensive Plan for review to the stakeholders as a follow up to the full-day meeting. The Plan was also presented for review and discussion during a Public Hearing conducted on September 13, 2002 in Columbia, SC. All comments received have been edited/ incorporated into the final Comprehensive Plan. Additionally, a small workgroup made up of consortia and DHEC staff spent one day discussing and modifying the draft plan.

Overview

The Comprehensive Plan is organized according to the 14 areas of need identified in the SCSN. These areas of need are listed below, not in any priority order.

Areas of Need for PLWHA

1. Medical Care
2. Medications Compliance
3. Confidentiality
4. Mental Health Counseling
5. Dental Care
6. Emergency Financial Assistance
7. Housing
8. Nutrition
9. Substance Abuse
10. Transportation
11. Client Education
12. Provider Education
13. Community Education
14. Care Services Infrastructure

Each area of need described in the Comprehensive Plan begins with a presentation of the barriers, gaps, and needs as identified in the SCSN development process. Long-term goals for the year 2006 are described, followed by strategies to accomplish the goals. Both primary and secondary strategies are listed. Primary strategies are those that would require no or few additional resources to implement. Secondary strategies would require significant additional resources. Some strategies may not be applicable for every consortia model. Some editing of the originally proposed strategies has occurred to assure strategies are within reasonable funding limitations.

Following the 14 areas of need, strategies are also described to address the specific needs of PLWHA that are eligible for, but **not** receiving, Ryan White services as well as for addressing the needs of PLWHA populations that have been historically underserved.

1. Medical Care

Barriers

- Separate facilities to obtain primary and specialty care
- Difficulty in making appointments
- Patients not keeping appointments
- Low incomes, below poverty level
- Ineligible for Medicaid/Medicare
- Clinic hours not available for those with daytime working hours

Gaps

- Lack of consistent primary and specialty care in rural areas
- Lack of funding for Hepatitis B and C treatment
- Lack of health insurance for medical care
- Lack of funding for specialty referrals
- Clients without care partners ineligible for in-home hospice

Needs

- Access to consistent primary and specialty care and supportive services.
- Provider training for rural and/or small providers.
- Delivery of quality medical services along a full continuum of care.
- Additional funding/partnerships for specialty referrals.

Long-Term Goal: By January 2006, PLWHA will have convenient access to comprehensive primary and specialty care.

Primary Strategies

1. By July 2004, consortia will use SCATN and other available resources to ensure that providers are meeting accepted standards of care.

2. By January 2005, consortia will collaborate with providers and other stakeholders to develop a plan to improve continuity of care.

3. By June 2005, consortia will create partnerships with local providers to promote access to support services, such as having DSS Medicaid workers on-site.

Secondary Strategies

1. By July 2005, consortia will establish on-site outpatient medical clinics to provide comprehensive primary and specialty medical care.

2. By January 2006, consortia will create partnerships to provide funding for specialty care such as cardiology, gynecological, neurology, gastroenterology and ophthalmology.

2. Medications Compliance

Barriers	Gaps	Needs
▪ Fear of government programs ▪ Fear of family, others learning HIV status ▪ Side-effects of medications ▪ Low self esteem ▪ Denial ▪ Complex drug regimens	▪ Lack of funds to pay for meds ▪ Difficulty in obtaining medications	▪ Client assistance in understanding and adhering to drug regimens ▪ Demonstration of care, honesty, trustworthiness by service providers ▪ Safety net for estranged clients ▪ Client assistance in accessing the ADAP.

Long-Term Goal: By January 2006, PLWHA will have increased medications adherence.

Primary Strategies

1. By January 2003, consortia will give pill organizers to clients on medications as needed.

2. By January 2003, consortia will establish buddy systems to assist clients with medications compliance.

3. By July 2003, consortia staff will collaborate to provide support mechanisms for clients at-risk for poor adherence.

4. By July 2003, consortia staff will actively market ADAP to clients in care and will reach out to clients not presently in care through agreements with health departments and other testing sites.

Secondary Strategies

1. By January 2006, each consortium will establish an intra-disciplinary team to conduct home visits and advise patients of interventions to increase medications adherence.

2. By January 2006, consortia will provide alarm watches to clients, as needed, to remind them when to take medications.

3. Confidentiality

Barriers	Gaps	Needs
▪ Primary medical staff insensitive to client need for confidentiality ▪ Specialty medical staff insensitive to client need for confidentiality	▪ Lack of proper sensitivity training for medical staff ▪ Lack of proper confidentiality procedures in place	▪ Office procedures and practices demonstrating commitment to confidentiality ▪ Sensitivity training for medical staff ▪ HIPAA training and compliance

Long-Term Goal: By January 2006, PLWHA will have their confidentiality protected by all state and federal guidelines and those deemed necessary by the client's consortium.

Primary Strategies

1. By April 2003, consortia will provide training to their staff regarding the need for adherence to confidentiality laws and procedures.

2. By April 2003, consortia staff will place a statement of confidentiality in view of all clients seeking services.

3. By April 2003, consortia staff will give a "Confidentiality Bill of Rights" to all clients during the intake process.

4. By April 2003, service providers, support staff, and volunteers will sign a confidentiality statement upon employment or involvement with client services.

5. By April 2003, consortia staff will explore the feasibility of eliminating the use of sign-in sheets and converting to an anonymous identifier number system, when appropriate.

Secondary Strategies

1. By January 2006, consortia will have established staffing and clinic flow that will eliminate waiting time at the provider's facility, as appropriate.

2. By January 2006, consortia will provide transportation for clients in rural areas who prefer to seek services in surrounding counties in order to protect their confidentiality, as appropriate.

4. Mental Health Services

Barriers	Gaps	Needs
▪ Manifestations of depression ▪ Limited or no coping and/or stress reduction skills	▪ Lack of health insurance for mental health ▪ Limited access to mental health care	▪ HIV+ support group ▪ Mental health counseling and treatment ▪ Improved access to mental health assessment and treatment

Long-Term Goal: By January 2006, PLWHA will have timely access to comprehensive mental health counseling services.

Primary Strategies

1. By June 2003, case management service providers will utilize an agreed upon, standardized mental health-screening tool for the assessment of each client.

2. By June 2003, medical providers will routinely obtain complete medical records, including psychiatric records, upon initial client intake and evaluation.

3. By June 2003, consortia will secure support group space and conduct support groups in culturally appropriate local settings.

4. By January 2004, DHEC and consortia will establish a database of mental health providers willing to serve PLWHA for a predetermined fee.

5. By June 2004, DHEC and consortia will explore developing collaborative partnerships with federal community health centers to secure access to and funding for specialty mental and behavioral health services.

Secondary Strategies

1. By June 2003, medical providers will have a licensed mental health counselor, psychiatric nurse, and/or psychiatrist as in-house staff.

2. By June 2004, consortia will have a trained, paid peer counselor as in-house staff.

5. Dental Care

Barriers	Gaps	Needs
▪ Costly for individual ▪ Costly for care consortium	▪ Lack of identified providers ▪ Lack of preventive care; service limited to extractions ▪ Lack of physical access to dental appointments	▪ A pool of dental providers in each consortium ▪ A continuum of dental services ▪ Subsidies for dental services ▪ Training for potential and existing providers ▪ Transportation to and from dental providers

Long-Term Goal: By January 2006, PLWHA will have access to dental care that is timely, affordable, well coordinated, and appropriate for client needs.

Primary Strategies

1. By July 2003, consortia will identify local dental providers to determine scope of services, fees, and payment schedule and willingness/capacity to provide services.

2. By January 2004, consortia will secure contractual agreements with dental hygiene schools and other potential collaborative partners willing to provide dental services to PLWHA, as appropriate.

3. By July 2004, the SC AIDS Training Network will offer trainings in each consortium service area for dental professionals interested in serving PLWHA.

Secondary Strategy

1. By January 2006, consortia will provide transportation for all dental patients, as needed.

6. Emergency Financial Assistance

Barriers	Gaps	Needs
▪ Poverty ▪ Very low income ▪ Not currently working ▪ High unemployment ▪ Low education levels	▪ Lack of employment placement assistance ▪ Lack of affordable educational opportunities ▪ Lack of financial counseling and planning	▪ Back to work program(s) ▪ Career planning ▪ Employment training, retraining ▪ Client financial/budgeting training

Long-Term Goal: By January 2006, the critical financial needs of PLWHA will be met.

Primary Strategies

1. By December 2003, consortia will offer ongoing financial assessment, planning, education, and assistance for clients, as needed.

2. By December 2003, consortia will improve coordination among local financial assistance resources and disseminate information about these resources to clients and case managers, to include financial counseling.

3. By January 2004, providers will identify and access additional sources of local financial assistance for PLWHA.

4. By December 2003, consortia will identify employment training and job placement resources for client referrals.

Secondary Strategy

1. By January 2004, providers will offer financial assistance for circumstances that are currently minimally covered and will increase existing coverage amounts over previous years.

7. Housing

Barriers	Gaps	Needs
▪ The high cost of quality, safe, decent housing ▪ Stigma, NIMBY syndrome (Not In My Backyard)	▪ Lack of quality, safe, affordable housing (rural and urban) ▪ Extended care housing options accepting HIV patients ▪ Lack of in-patient hospice	▪ A continuum of housing options including transitional, supportive, in-patient hospice and long term ▪ Emergency housing, temporary shelter

Long-Term Goal: By January 2006, there will be an increased supply of safe and affordable transitional and permanent housing for PLWHA and their families in both rural and urban areas of the state.

Primary Strategies

1. By June 2003, consortia will collaborate with housing partners to assess statewide inventory of existing public and transitional housing available for PLWHA.

2. By December 2003, consortia will use the statewide inventory to maximize use of existing housing options.

3. By June 2003, consortia will conduct a statewide assessment of client housing needs.

4. By January 2004, consortia will collaborate with existing housing agencies to develop a plan to address unmet housing needs.

Secondary Strategy

1. By January 2006, consortia will contract with the local housing authorities statewide to set aside rental assistance vouchers for PLWHA and their families.

8. Nutrition

Barriers	Gaps	Needs
▪ Nutritional needs viewed as secondary to medical needs	▪ Lack of dietary counseling	▪ Dietary counseling

Long-Term Goal: By January 2006, PLWHA will have appropriate access to nutritional services.

Primary Strategies

1. By January 2004, providers will distribute nutritional information.

2. By January 2004, consortia will collaborate with schools, churches, and businesses to sponsor food drives.

3. By January 2004, consortia will develop a local list of nutrition resources available in each county including nutritional counseling, financial assistance, food banks, food stamps, and supplements.

Secondary Strategies

1. By July 2004, consortia will have a trained nutritionist or dietician available to provide nutrition education and counseling for clients.

2. By January 2004, consortia will have transportation volunteers available to help distribute food and nutritional supplements to underserved populations, if appropriate.

9. Substance Abuse

Barriers	Gaps	Needs
▪ Use of alcohol and other drugs as a co-morbidity	▪ Lack of in-patient treatment beds ▪ Lack of out-patient treatment programs for dual-diagnosed (HIV/SA) ▪ Lack of appropriate supportive housing upon completion of treatment	▪ Access to substance abuse professionals ▪ Training for proper use of substance abuse assessments ▪ Provision of and/or referral to comprehensive substance abuse services ▪ Access to supportive services for clients released from in-patient programs

Long-Term Goal: By January 2006, PLWHA will have access to comprehensive substance abuse support services.

Primary Strategies

1. By June 2003, consortia will develop a comprehensive local list of alcohol and other drug (AOD) service providers in their region, including providers with in-patient treatment beds and programs for those with a dual diagnosis.

2. By July 2003, consortia will collaborate with AOD service providers to establish linkages and a referral system.

3. By March 2004, consortia will develop a plan to incorporate substance abuse assessments into service plans and for providing substance abuse services and referrals.

Secondary Strategy

1. By January 2006, consortia will provide intensive case management services to address AOD issues after PLWHA are released from inpatient substance abuse care.

10. Transportation

Barriers	Gaps	Needs
▪ No personal vehicle ▪ Rely on others for transport ▪ All day commitment when only contracted (DSS) transportation available ▪ Unreliable contractors for transportation	▪ Limited public transportation options – urban and rural	▪ Expanded public transportation options ▪ Reliable contract transport

Long-Term Goal: By January 2006, PLWHA will have increased access to safe, affordable transportation for medical care and complementary services.

Primary Strategies

1. By April 2003, consortia will research available transportation options and develop a list of transportation resources for clients.

2. By April 2003, consortia will allocate funds for gas cards, bus tickets, cab fares, and mileage reimbursement for clients and volunteers.

Secondary Strategy

1. By January 2005, consortia will collaborate to establish vehicle lease-to-own program for PLWHA using non-restricted funding.

11. Client Education

Barriers	Gaps	Needs
▪ Low literacy ▪ Low education level	▪ Lack of understanding of and commitment to self-care ▪ Lack of disease management skills ▪ Lack of ability to negotiate social services and disability eligibility requirements	▪ Skill development in self-management of HIV disease ▪ Trained social workers and paraprofessionals in systems negotiation ▪ Communication skills to work with health care providers

Long-Term Goal: By January 2006, PLWHA will be empowered to better understand and manage their disease, negotiate the service system, and communicate with their providers.

Primary Strategies

1. By January 2004, each consortium will establish a resource library for clients, to include Internet access.

2. By January 2004, consortia case managers will work with clients individually, as appropriate, to increase their capacity to manage their HIV and communicate effectively with their health care providers.

3. By January 2005, consortia will provide appropriate information to clients through patient forums, utilizing collaborative relationships (Title III, drug companies, etc.) to fund events.

12. Provider Education

Barriers	Gaps	Needs
▪ Judgmental attitudes ▪ Medical staff insensitive to client need for empathy	▪ Lack of ability or willingness to provide explanations and answers to patient questions ▪ Lack of knowledge of protocols for HIV medications, treatments, prevention in rural settings, and non-HIV specialties	▪ HIV psychosocial issues education for health care workers ▪ Time for patient conversation ▪ Immediate access to information/consultation for physicians and other practitioners with small HIV case loads

Long-Term Goal: By January 2006, all providers will deliver culturally competent care and treatment to PLWHA.

Primary Strategies

1. By January 2004, SCATN will establish a strong relationship with SCMA to increase opportunities for providers to receive training on cultural competence and HIV care services and treatment.

2. By June 2004, SCATN will train providers to conduct risk assessment and safer sex education in a non-judgmental manner.

3. By January 2005, DHEC and consortia will encourage schools of preparation for health care workers to incorporate classes on cultural competence as part of medical training before residency or internship.

Secondary Strategies

1. By January 2005, consumer advocacy committee will participate in a legislative advocacy campaign to advocate for medical provider education.

2. By January 2005, SCATN will offer quarterly cultural competency training opportunities for all providers, as needed.

13. Community Education

Barriers	Gaps	Needs
▪ Homophobia in the African American community ▪ Complacency	▪ Lack of education of social services providers, law enforcement and criminal justice personnel	▪ Community wide HIV awareness training ▪ Targeted sensitivity training

Long-Term Goal: By January 2006, consortia will link/collaborate with prevention to further educate communities about HIV risks, prevention skills, sensitivity issues, and existing care services.

Primary Strategies

1. By December 2003, consortia will collaborate with community opinion leaders (to include local clergy, as appropriate) to develop community education efforts designed to get PLWHA into care.

2. By December 2003, consortia will compile contact information for a local speakers' bureau.

14. Care Services Infrastructure

Barriers	Gaps	Needs
▪ Consortia and medical providers heavy workload ▪ Limited funding	▪ Lack of communication between medical providers and case management providers ▪ Lack of coordination with rural mental health centers and local drug and alcohol treatment facilities ▪ Centralized urban service providers offering services in rural parts of their service area ▪ Lack of linkages between care and prevention	▪ Clear communication between medical providers and case management providers ▪ Coordination with rural mental health centers and local drug and alcohol treatment facilities ▪ Urban service providers offering services in rural parts of their service area ▪ Collaboration between care and prevention service providers

Long-Term Goal: By January 2006, infrastructure will be strengthened to ensure accessible and coordinated care for PLWHA.

Primary Strategies

1. By April 2003, DHEC will continue to convene statewide meetings to showcase methods of communication and coordination among service providers in a consortium region.

2. By April 2003, care consortia will continue to collaborate with prevention service providers.

3. By January 2004, local stakeholders will develop plans to increase communication and coordination between medical and case management providers.

4. By June 2004, the DHEC medical consultant will work to facilitate collaboration between primary and specialty care.

5. By January 2004, DHEC will link health care providers with training opportunities provided by SEATC.

6. By January 2004, consortia will improve mechanisms for coordinating counseling and testing services and treatment services to ensure linkages to care.

7. By June 2004, consortia will establish relationships with rural mental health centers in their regions.

Secondary Strategies

1. By January 2006, urban service providers will have mobile care units to serve the rural areas of their regions.

Strategies to Serve Hard to Reach and Underserved Populations

There are many ways to describe the populations of PLWHA that have been traditionally underserved as well as those individuals who are eligible for, but do not access, Ryan White services. The following characteristics of these populations were identified by HIV/AIDS stakeholders in South Carolina:

Characteristics of Hard to Reach and Underserved Populations

- Disabled
- Dually diagnosed
- Economically disenfranchised
- Elderly
- Ex-convicts
- Gay
- Hearing impaired
- Homeless
- Incarcerated
- Low literacy
- Mentally ill
- Migrant workers
- People who do not speak English
- Persons with English as a second language
- Racial and ethnic minorities
- Rural residents
- Substance users
- Transgender
- Transient
- Unemployed
- Uninsured
- Women
- Women with children

The barriers to reaching these populations are complex and the strategies to serve them are varied. Listed below are 21 strategies specifically targeting hard to reach and underserved populations. Some strategies are focused on a specific area of need and others describe broader efforts to address multiple needs.

1. By January 2003, consortia will expand community outreach efforts and develop and implement other appropriate strategies to increase awareness of services for PLWHA and to encourage PLWHA to access care services.

2. By January 2003, DHEC and consortia will collaborate with DSS to better educate Medicaid recipients about available transportation services.

3. By January 2003, consortia will collaborate with African American rural churches to address transportation needs of PLWHA in rural areas.

4. By January 2004, consortia will increase the number of people on staff who are members of the populations they serve.

5. By January 2004, consortia will provide bilingual outreach and HIV care services for clients.

6. By January 2004, consortia will identify and disseminate information about opportunities for clients to take English-as-a-second-language classes.

7. By January 2004, consortia will train providers on culturally appropriate strategies for delivering services when the client and the provider do not speak the same language.

8. By January 2004, consortia will train pre- and post-HIV test counselors regarding all state and federal confidentiality guidelines.

9. By January 2004, DHEC will ensure that clients receive a literacy- and language-appropriate statement of confidentiality when they receive an HIV test and/or are contacted by a DIS worker.

10. By January 2004, DHEC and consortia will collaborate with DIS workers to locate clients and encourage them to access care services.

11. By January 2005, consortia will provide information about emergency financial assistance as part of outreach and HIV counseling and testing services.

12. By January 2005, consortia will collaborate with mental health providers to offer professional and peer counseling services in community setting appropriate for and accessible to underserved populations.

13. By July 2005, consortia will establish satellite clinics and utilize mobile clinics in underserved and rural areas.

14. By January 2005, consortia will arrange to provide intensive substance abuse case management, peer counseling, and outreach services in community settings to recruit clients for comprehensive care services.

15. By January 2005, consortia will provide on-site dental health assessment and referral services.

16. By January 2005, consortia will explore the feasibility of providing multiple services in one setting (i.e., one-stop shopping) and coordinating the location and timing of services for mothers and their children.

17. By January 2006, consortia will explore offering incentives to PLWHA who participate in workshops and trainings on empowerment and other topics related to HIV management and care.

18. By January 2006, consortia will use paid peer educators to do home visits to encourage PLWHA to access needed services.

19. By January 2006, health care clinics will offer more flexible hours and more frequent clinic days.

20. By January 2006, DHEC and consortia will collaborate to develop social marketing campaigns aimed at reducing community and provider stigma about HIV.

21. By January 2006, consortia will research opportunities for education and job training to empower underserved populations to become financially self-sufficient and to purchase their own transportation.